

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address: EL PASO SPECIALTY HOSPITAL 1755 CURIE DR STE A EL PASO TX 79902-2907	MFDR Tracking #:	M4-03-8049-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: Texas Mutual Insurance Co. Box #: 54	Date of Injury:	
	Employer Name	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We do not believe the reduction is justified. As you are likely aware, such provider reimbursement rates are typically adjusted based on the usual and customary treatment charges for that specialty and the geographical region where treatment was provided. Further, many state and federal disclosure laws require insurers and administrators to advise beneficiaries and providers as to how the reimbursement rate is determined. However, the payment rendered does not appear to be comparable to rates charged for this service locally and no information has been given to support your position that the denial is correct."... "Based on this information, we request that the reductions be reversed and an additional payment be made."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - \$1,581.43
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Carrier's payment is compliant with TWCC Rule 133.304"... "The requestor failed to prove its billing of usual and customary is fair and reasonable"... "The requestor's billed amount for the facility charges related to the 03/14/03 performed as an outpatient is neither fair nor reasonable."... "The requestor's billed amount for this procedure and payment of same by a carrier does not achieve effective medical cost control."... "no additional payment is due"... "This carrier's payment is consistent with the fair and reasonable criteria established in Section 413.011(b) of the Texas Labor Code."... "This carrier has met the requirements of TWCC Rule 133.304133.307(j)(1)(F)"

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
3/14/2003	M, O, YO, RD	Outpatient Surgery	\$1,581.43	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - M – “No MAR”
 - O – “Denial after reconsideration”
 - YO – “Reimbursement was reduced or denied after reconsideration of treatment/service billed.”
 - RD – “The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(b).”
2. This dispute relates to outpatient surgical services provided in a licensed ambulatory surgical center with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011”...
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(g)(3)(C), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including “a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor’s reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue. The request for medical fee dispute resolution was received by the Division on June 25, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on July 3, 2003 to send the additional required documentation. Additional information was received from the requestor on July 11, 2003 and on December 8, 2008. Review of the submitted documentation finds that the requestor did not state its reasoning for why the disputed services should be paid; or how the Texas Labor Code and Division rules impact the disputed fee issues; or how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
5. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement”... The requestor’s position statement does not articulate a methodology under which fair and reasonable reimbursement should be calculated. The requestor’s rationale for increased reimbursement from the Table of Disputed Services states “F&R according to our region” but does not further discuss or explain how the amount in dispute was calculated or arrived at. The requestor does not explain how it determined that payment of \$1,581.43 would result in a fair and reasonable reimbursement for the services in dispute. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.